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ABSTRACT

This document is one of seven publications contained in a series of materials for physicians on recognizing, intervening with, and treating adolescent alcoholism. The goals of this unit of study are to provide an overview of the problem of of teenage alcoholism and substance abuse and to facilitate the diagnosis of adolescent alcoholism. The information provided is designed to help the physician develop a greater understanding of the progression of alcoholism and substance abuse and a sensitivity to the manifestations of teenage alcoholism and substance abuse seen in clinical practice. This unit of study will enable the physician to: (1) describe the model of alcohol and other substance abuse as a progression of events usually moving from experimentation to dysfunction; (2) differentiate behavioral and psychological patterns or traits associated with each level of the progression; (3) describe behavior patterns which would likely be exhibited by an adolescent harmfully involved with alcohol; (4) describe the use of medical interviewing techniques in the attainment of a substance abuse history; (5) list risk factors relevant to substance abuse and describe how physical examination and laboratory tests are used as part of the evaluation; (6) synthesize data to make an accurate diagnosis and an assessment of substance abuse; and (7) assess personal skills as related to a patient's level of substance involvement to determine appropriateness of providing care, consulting, or referring. (NB)

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Adolescent Alcoholism: Recognizing, Intervening, and Treating

(The titles and materials listed below are contained in this series.)

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2. The Physician's Role in Prevention	*	*	
3. Recognition and Diagnosis	*		*
4. Intervention with the Dependent Adolescent	*		*
5. The Physician's Role in Referral and Treatment	*		*
6. Alcohol and Other Chemicals	*		
Faculty Guide (regarding medical education, residency training, and continuing medical education)			*

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Adolescent Alcoholism:
Recognizing, Intervening, and Treating

3 Recognition and Diagnosis

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Introduction

In the 19th century, the famous pathologist-physician, Sir William Osler, described syphilis as the "Great Pretender." Osler recognized how the signs and symptoms of this disease, at each of its stages, could readily mimic those of other conditions. Because the disease was so common at that time — and so difficult to control — the physician was wise to consider syphilis as the actual cause of the disease which a patient was presenting.

Today, alcoholism and, in a larger sense, chemical dependency might be seen in the same way. While every physician is familiar with the end-stage ramifications of chronic alcoholism, which may entail impairment of virtually every organ system, the signs and symptoms of many psychological and psychiatric abnormalities are mimicked by the effects of the abuse of alcohol and other mood-altering chemicals. Depression, anxiety, paranoia, and the like are frequently misdiagnosed when the actual cause is, in fact, the abuse of psychoactive chemicals.

The primary care physician assessing adolescent patients is unlikely to see many of them presenting end-stage physical ramifications. Instead, the consequences will be more likely to present in the psychological and social domains. The intent of this unit of study is to increase your awareness of these domains and to heighten your willingness to explore the possibility of alcohol and drug abuse among your patients. This discussion will provide physicians with an overview that can help in the recognition of the abuse of these substances in both the adolescent and his or her family. The models to be presented — of the development and progression of use/abuse and of family functioning — are certainly not exhaustive. Extensive literature on causation, development, and family dysfunction related to these conditions exists and is referenced in other units of study of this series. Here we provide a schematic which may help you recognize these conditions as they present in your patients.

The unit of study recognizes that the primary care physician may not be the health professional who will actually manage the case and provide the alcohol or drug abuse-specific treatment once these conditions have been identified. Instead, the intent is to offer physicians information and skills which will help them obtain a valid and reliable history and will facilitate an appropriate assessment of a chemical-related problem.

Goal

The goal of this unit of study is to provide an overview of the problem of teenage alcoholism and substance abuse and to facilitate the diagnosis of this threat to health and well-being. In reaching this goal, the physician will develop both a greater understanding of the progression of alcoholism and substance abuse and a sensitivity to the manifestations of teenage alcoholism and substance abuse seen in clinical practice.

Objectives

Upon completion of this unit of study, you will be able to:

1. *Describe the model of alcohol and other substance abuse as a progression of events usually moving from experimentation to dysfunction.*
2. *Differentiate behavioral and psychological patterns or traits associated with each level of the progression.*
3. *Describe behavior patterns which would likely be exhibited by an adolescent harmfully involved with alcohol.*
4. *Describe the use of medical interviewing techniques in the attainment of a substance abuse history.*
5. *List risk factors relevant to substance abuse and describe how physical examination and laboratory tests are employed as part of the evaluation.*
6. *Synthesize data to make an accurate diagnosis and an assessment of substance abuse.*
7. *Assess personal skills as related to a patient's level of substance involvement to determine appropriateness of providing care, consulting, or referring.*

Recognition: The Progression Hypothesis

The progression hypothesis of substance abuse lists several categories of users and defines behavioral attributes and psychological features within each category.

Introduction

An effective model of substance abuse should, at the very least, make it possible to distinguish different categories of users. It also must describe how a user's "career" begins and ultimately where it can terminate. The Progression Hypothesis provides such a model.[1] Originally developed by Chambers in the early 1970's to categorize epidemiological findings, Dr. Siegal, first author of this unit of study, has used it extensively in clinical work with adolescent substance abusers. The model provides definable categories of users, distinguishes between the categories with specific behavioral attributes, and provides some insight into differences in psychological and social functioning between the categories. This model assists the physician in evaluating adolescent patients by

- referencing where they are in their drinking or substance use career;
- logically sequencing intervention activities;
- avoiding the nonproductive, false dichtomy about "good" versus "bad" drugs;
- visualizing drug use in dynamic rather than static terms; and
- focusing the patient's and the family's attention on the actual consequences of use.

Among adolescents, it is nonproductive to distinguish alcohol from other mood-altering drugs. Unquestionably, alcohol has greater availability and use than do other substances, and the ramifications of alcohol abuse among the teenage and young adult group — especially in the area of automobile-related fatalities — is likely to be more profound. However, the dynamics of use and progression are similar. Also, the sole abuse of any single agent tends to be rare in a sophisticated user. The scary point about the adolescent patient is that this progression may be extremely rapid — less than a year.

The Progression Hypothesis

The Progression Hypothesis is represented in Figure 3-1. It initially distinguishes between users and non-users; that is, those who abuse psychoactive drugs and those who do not. The latter category, although psychologically and sociologically interesting, will not be reviewed here. Instead, attention will be focused upon the significantly larger category of "users." Each of the groups within the model is briefly described below.

Experimenters

The first category of use is the experimenter who is doing, in most situations, what is a normal activity of adolescence.

Experimentation is a normal form of human activity. Most people exhibit a willingness to experiment with new things in their environment in their life-long quest for satisfaction and fulfillment. Stated much more directly, we desire to "try" new foods, styles, and activities. Among the things that are experimented with is how the mind categorizes, organizes, and experiences the data being brought to it by its externally and internally focused senses. This has been referred to as the "state-of-consciousness."

This function can be manipulated in numerous ways. Altered states can be achieved by strenuous physical activity; for example, the "runner's high," fasting, hyperventilation or hypoventilation, medication, sleep deprivation, pain, and ingesting psycho-active chemicals. Some writers have even suggested that mankind possesses an innate drive to periodically alter the state-of-consciousness. Anthropologic and developmental data have been offered to support the "inborn drive" hypothesis.[2] They claim a culture has yet to be discovered in which its members do not have some method of altering consciousness. Even very young children will alter perceptions through behavior, such as spinning to become dizzy.

As a culture, we accept the periodic alteration of state-of-consciousness as desirable. While there is certainly some ambivalence, our culture endorses the moderate use of alcohol as one means to do so. In fact, experimentation with alcoholic beverages is considered one of the milestones of adolescent life. However, experimentation is seldom a single event. Instead, it is a "testing" or "sifting" process by which people evaluate the effects of use (whether they "like" the feelings) and

Figure 3-1. Progression Hypothesis

LEVELS OF USE	BEHAVIORAL ATTRIBUTES	PSYCHO-SOCIAL CHARACTERISTICS
Experimenters	Users	Self-Reliance
Social Users	Imitative Behavior	Self-Confidence
	Peer-Initiated	Self-Control
	Recreational	Goal-Oriented
		Satisfaction with Current and Future Roles
Committed/Harmfully Involved Users	Seekers Adaptive Behavior	Depression Anxiety
Dysfunctional Users	Self-Sustained	Alienation
	Self-Medication	Role Frustration
		Low Tolerance for Stress and Tension
		High-Risk Taker
		External Stimulus Seeker
		Poor Reality Testing

determine how such effects "fit" with those from other activities and relationships.

Social and Recreational Use

The next category of use is the social and recreational use of alcohol; this level of use does not usually interfere with the individual's daily activity.

During experimentation, people try to determine not only whether they like the results but also if the consequences are either too unpleasant or too painful. If both decisions are positive, then progression to the next stage or category in the model designated as "Social and/or Recreational Use" may ensue.

Social and recreational use does not interfere in any kind of significant or consistent way with any of the user's other responsibilities or roles. The use, when observed or known to others, typically does not engender strong negative sanctions; it is considered "appropriate" for the individual's current position. Moreover, the patterns in which use is organized place the user at low risk for problems.

Some explanation is necessary at this point. It should be clearly understood that use by adolescents is not being sanctioned. Instead, the intent is to categorize usage patterns by their consequences or risk. While few would question the capacity of most adults to drink socially and recreationally, the activity is clearly more difficult to support for adolescents. If drinking or drug use may interfere with an adolescent's acquisition and mastery of social or psychological skills, then it is no longer simply social or recreational. Furthermore, what is seen as nonproblematic for one age group may certainly be for another. An 18- or 19-year-old's weekend drinking cannot be considered in the same light as that of a 14-year-old. The problems are as much in the perceptions of the behavior by others as in the behavior itself. As such, it is essential that use by an adolescent is viewed in this larger context.

Harmfully Involved/Committed Users

The next user category is the harmfully involved/committed user; this type of user has impairment in major life areas.

A heavy line separates the first two categories of the model from the latter two. While experimental and social use are defined as "normal," the latter two are seen as pathological. Experimental and social/recreational use presents only a small risk for problems. This is not to imply that such use will not cause difficulties; but should they occur, users quickly alter usage patterns or avoid them entirely.

Two illustrations will help make the "normal" vs. "pathological" distinction clear. First, let us consider adults. Many adults drink alcohol, and it gives most no difficulty. Also, most adults drive automobiles. However, should adults ever put the two together (that is, drink alcohol and drive), they are at risk for a DWI (Driving While Intoxicated) citation, or worse, a serious automobile crash. Either tends to be a very unpleasant, embarrassing, and ultimately expensive experience. For most people to whom it happens, the attendant difficulties are enough to convince them not to do it again. Because of the severe consequences and their recognition of their own vulnerability, they are unlikely to place themselves in jeopardy again.

A similar scenario can be offered for an adolescent who sustains a disciplinary proceeding at school because of a violation of school rules pertaining to alcohol or drug use. The fact of the discovery and the impact of the sanctions imposed, coupled with the understanding that he did get caught, are enough to engender a behavioral change. Experimenters and social and recreational users are not willing to continually jeopardize important activities. Others, however, do not alter their problematic behaviors because they are either committed to a lifestyle for which this substance use is necessary; or, they are harmfully involved, meaning they do not have the ability, without external assistance, to effect any permanent change in their use, even if they want to.

Those placed in the Committed/Harmfully Involved category are likely experiencing impairments in some of their major life areas, such as

- family,
- school (or employment),
- social relationships,
- self-concept and self-esteem,
- psychological functioning, and/or
- health.

Problems consistently will appear first in the family realm and then surface at school or with the law. It is behavioral problems that are usually noticed. The most frequent will be extreme mood swings, combativeness, isolation, apathy, and radical changes in appearance and peer group associations. Because adolescence represents such a period of change and turmoil, it is unlikely that such changes will be initially attributed to either drinking or drug use. The recognition of the relationship between behavioral problems and the use often comes only with intervention.

Persons in this third category are still integrated into the major societal institutions. While they are alienated and the family is operating under considerable stress, "normal" function is still possible. School or job performance is impaired, but the abusers remain involved in these activities and continue to claim their importance while disclaiming their satisfaction with them.

Without intervention, persons who are harmfully involved are likely to see their substance use as entirely under control, as causing no real problems; and any difficulties that they may be experiencing are caused by others — teachers, parents, meddlesome friends — committed to persecuting them.

Dysfunctional Abusers

The final stage is the dysfunctional abuser; life has been disastrously affected by alcohol use. Unfortunately, this may result from a rapid progression in adolescence.

Those in the final or "dysfunctional abusers" category present as individuals with substance-abuse-caused problems so overwhelming that the supports provided by family and occupation or school have been removed. The family has disintegrated or has disinherited them; they have been expelled from school; they cannot hold a steady job. Each area of life has been disastrously affected by substance abuse. They have, in effect, expended all of their social and material resources.

A Summary of the Typology

The Progression Hypothesis presents a comprehensive way to view alcohol and drug use with a population.

While virtually everyone begins as a "nonuser," many, if not most, will at least experiment with alcohol, and many others will experiment with additional psychoactive drugs. Fortunately, most remain at the experimental and social/recreational level, and only a few, for reasons not clearly understood, will become harmfully involved or worse.

The Progression Hypothesis is especially useful to the physician because it encourages a consideration of the ramifications or consequences of use on function. Until functional impairment (that is, repeated disruption of one or several of the eight major life areas) has been documented, then the issues surrounding use patterns can be seen primarily in terms of vulnerability or risk. In this case, intervention is more difficult than when harmful involvement can be established.

Behavioral Attributes

The first two categories of users are characterized by alcohol use which is peer-initiated, imitative, recreational behavior.

For purposes of assessment, additional distinctions between the "normal" and "pathological" should be made. The second column in Figure 3-1 portrays the behavioral attributes of those in the experimental and social/recreational groups; they are designated as "Users." Those in the harmfully involved and dysfunctional categories are described as "Seekers." "Users" report that alcohol does something to them. They report enjoying the taste, the conviviality surrounding consumption, and the altered perceptions that are being experienced. Use constitutes imitative behavior — behavior that is peer-initiated and peer-sustained. It is recreational, and it occurs in such a way that neither developmental tasks nor role expectations are consistently impaired.

The last two categories ("seekers") are characterized by alcohol use which is self-initiated, adaptive, and a self-medicating behavior.

"Seekers" report that alcohol does something for them. The effects provide them with something that they perceive as lacking. For example, problem drinkers report that, when they drink, they feel more powerful, more in control of themselves and their environment, more potent, and more attractive. Alcohol and other substance abuse is the "Seeker's" way of adapting in an environment that is perceived as unpleasant or hostile. It is a direct way to avoid the painful tasks of maturation such as learning how to cope with feelings of rejection, uncertainty, and insecurity.

Because the effects are so predictable, the abuse is self-reinforcing, and the behavior is self-sustained. Without alcohol, the harmfully involved adolescent perceives little consistency in how he will be treated by peers, family, and others; little control or satisfaction is expected. Alcohol, however, consistently offers the desired effect.

Those who are harmfully involved have learned that they can chemically cope with the painful feelings of depression, anxiety, and stress. They are, in effect, medicating themselves.

Psychological and Psychosocial Attributes of User Groups

Psychological attributes of experimenters and social users include self-reliance, self-confidence, goal orientation, and role satisfaction.

The third column in Figure 3-1 portrays the significant differences in the psychological characteristics of those who are harmfully involved and those who are not. The debate about whether substance abuse is the "cause" or the "result" of these dysfunctional conditions is nonproductive. From a patient management perspective, all nonmedical use must be terminated before any effective treatment can be initiated.

For those who are not harmfully involved, standard psychometric instruments provide nonremarkable results. Perhaps one of the most sensitive indicators is the "orientation to present or future roles." The perception that you will likely have is that young people who are essentially satisfied with where they seem to be going are the least problematic.

Psychological features of the last two categories include alienation, role frustration, anxiety, depression, poor reality testing, and risk-taking activity.

Conversely, those who are harmfully involved show little direction or satisfaction. The picture they present emphasizes alienation, depression, and anxiety. Look for acting-out behavior — such as combativeness — in young men and sexual difficulties — most likely promiscuity — in girls. Change and lack of definition are handled poorly since stress and environmental tension are not tolerated well. Because they have created an elaborate psychological defensive system to protect their usage, it is unlikely that they will be able to understand the concern that others are exhibiting about their situations. This concern will typically be seen in negative terms.

Assessment and Therapeutic Assignment

Assessment of where in the progression the teenager is allows better formulation of a treatment plan. The final two categories of users need formal treatment.

The physician's task is two-fold here: (1) determining where in the progression the patient currently is, and (2) recommending the most appropriate service.

The task confronting the physician in assessing the substance-abusing patient is to determine where the patient is in the progression. Having done so, it becomes possible to determine an appropriate level of service. For those adolescents who are not committed/harmfully involved, yet still demonstrating some vulnerability, prevention activities and education are appropriate. For those who are committed/harmfully involved and the dysfunctional users, formal treatment is necessary. Factors relevant to determining the choice of treatment modality — such as residential versus outpatient treatment — would include the findings of medical assessments, motivation toward treatment, drinking patterns, and availability of resources. Treatment alternatives and modalities for alcohol abusers are discussed at length in a subsequent unit of study of this series.

The Family and Chemical Dependency: Its Impact Upon the Diagnostic Process

Introduction

If chemical dependency mimics and compounds dysfunctional signs and symptoms found within the individual, the mimicry and confusion are even greater when applied to a family system. If one member of the family is chemically dependent, the entire family will be affected.

The purpose of this discussion is not to present an exhaustive description of the family confronted by dependency or abuse by one of its members; instead, it is to help sensitize the physician to the signs and symptoms indicative of these conditions as they manifest themselves in the family system. In a real sense, it is assumed that the degree of familial dysfunction is likely related to the extent and severity of the problems of its individual members.

Seen in systems terms, the family is an entity which attempts to maintain its equilibrium or balance. As such, it alters its configuration in response to behavioral changes by its members. We must remember that the period of adolescence is one of the most difficult and stressful for both the young person and the family. The major developmental tasks involving the construction and testing of a separate identity along with the need to disengage from the family are well underway. At best, adolescent behavior will be inconsistent; more realistically, inconsistent and periodically problematic. The physician making any kind of behavioral assessment must move beyond reports of discrete incidents and search for emerging patterns which may indicate alcoholism or drug abuse.

Experimentation: Initial Concern in the Family

The physician can serve as a resource for the teenager and family in the experimentation stage while always being watchful for "something wrong."

In the family confronted for the first time with drug or alcohol experimentation by a teenager, there is uncertainty about the meaning of the behavior. Generally, parents are more concerned about experimentation with drugs other than alcohol simply because they have had

less direct experience with them. Moreover, social norms surrounding experimentation with alcohol are better known, and parents may look back to their own experiences to define the incident.

It also is important to maintain some perspective about age and development. What is acceptable for a 19-year-old may not be acceptable for a 15-year-old. While experimentation may occur at any age, very early experimentation may be indicative of a problem. If you sense that something is not quite right when considered in light of your understanding of the adolescent and the family, you should accept the perception as a vital component in your assessment process.

If you feel that the adolescent's use is actually at the experimental or social/recreational level, you can serve as an information resource for your patient and the family. Take care not to become enmeshed in family strife about freedom, choice of friends, etc., because if you seem to be taking sides, your credibility as a source of information and assistance will be compromised. We do not mean to imply that the physician should never take a stand; such would be irresponsible. Be aware that in their attempt to resolve conflict and strife, family members will look to persons outside of the system to validate their opinions and wishes. However, offering pronouncements about what is acceptable behavior for a teenager in the context of that family is not likely to be productive for the physician in the long run. Be definitive about the presence of stress and tension, then focus on issues such as vulnerability and that behavior can have real consequences. It is through education and counseling services that families will reach an understanding of acceptable behavior.

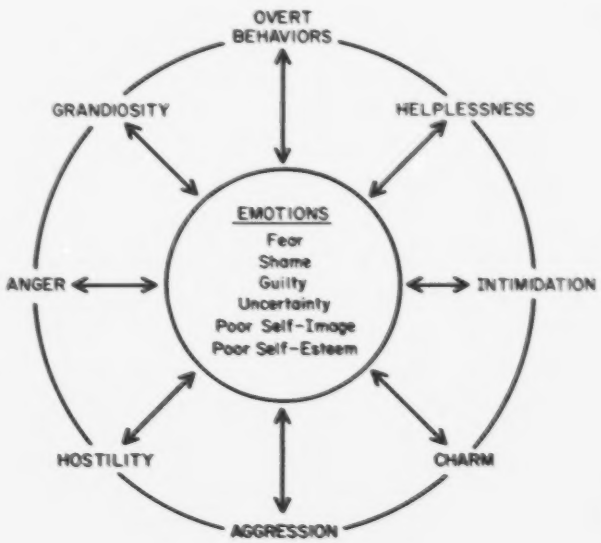
Committed/Harmful Involvement: The Family Responds

With harmful involvement, youth may have inner emotions disguised by outer signs of charm, hostility, or helplessness. The family often has poor communication and hides the problem.

If the abuser is harmfully involved with drugs, he is either unwilling or unable to recognize the extent of involvement and likewise to appreciate the severity of the problems being experienced. Therefore it is unlikely that he will attempt to effect a consistent change in either personal behavior or in treatment of other family members. In these states, there is a discontinuity between affect and observable output-behavior. Some writers have characterized this as a "two-layered ring" (Figure 3-2). In this conceptualization, the inner feelings are those of anger, guilt, shame, fear, and a very low self-image or self-esteem. Conversely, the externally observable behaviors vary between anger, hostility, aggressiveness, charm, intimidation, helplessness, and grandiosity.

To appreciate the dynamics of substance abusers' behaviors, one must understand that chemically dependent persons need to protect their abilities to continue drinking or using drugs. In the case of harmful involvement, it is the relationship with mood-altering drugs that has become the most important aspect in their lives. The perceived positive relationship is reinforced each time they experience the anticipated effects of the drug(s) since they are more predictable and viewed as more consistently pleasurable than the interaction with family members and others.

Figure 3-2. Discontinuity Between Affect and Behavior



Thus, in the family system in which an adolescent member is chemically dependent, one typically will find the following:

Poor Communication—Interaction in the family is only at the most superficial levels. It is characterized by an unwillingness or inability to meaningfully confront and resolve any family-related issues (View/Discuss Video VIIa).

Intimidation—Recognition or acknowledgement of drug or alcohol involvement evokes a response by the teenager of overt hostility and anger. The behavioral response is so immediate and so full of much threat that it discourages family members from approaching any subject — regardless of how tangential — related to use.

Purposeful Hiding and Obscuration—Any direct mention of use or signs suggesting it are carefully obscured by elaborate schemes. Passivity and non-communication provide complementary vehicles for the adolescent in his desire to control interventions by family members.

While these behavioral characteristics are described separately, experientially they are inseparable. Without consciously trying, families in which a member is harmfully involved engage in what is typically referred to as "a conspiracy of silence." Through it they avoid the risk of disrupting the family system's equilibrium. This mechanism is responsible for the "denial-of-problem" by family members when intervention is first attempted by others external to the system (View/Discuss Video I). The harmfully involved individual also has defense mechanisms, just as does the family; these are discussed in Unit of Study 4, Intervention with the Dependent Adolescent, along with management suggestions for some of these specific familial issues.

The family equilibrium is sustained by the behavior and interactional patterns presented here. The family system is now functioning at a level structured to accommodate the behavioral changes which have occurred in its impaired member. The equilibrium discourages changes by family members who fear even greater disruption and uncertainty in their lives. Besides the usual reticence that many people have in revealing what they feel to be shameful or unpleasant information, the fear of even greater changes occurring in their lives now encourages these family members to withhold information from the physician (View/Discuss Video IX).

The Physician as Diagnostician

Introduction

The physician's role in the diagnostic process is described and outlined early to the involved family, as well as what role will be played when treatment is begun.

The physician usually becomes aware of substance abuse problems in one of the family's members when some disruption occurs within a major life area. In the case of the adolescent member, these problems can present as brushes with the law, behavioral or academic problems in school, automobile accidents, the discovery of drugs, drunken incidents at home, an overdose, or radical changes in behavior. Often, another family member brings the matter to the physician's attention, or the physician may first be presented with the patient, such as in an overdose situation. The task of the physician is to evaluate the extent and severity of the adolescent's use and problems by obtaining data from family members, the patient, and other available sources. These data will help with the assessment of the problem.

Initial sections below will consider the diagnostic process as it relates to individuals and families. Final sections will describe the assessment process itself. In obtaining information, the physician instantly runs into the confidentiality issue. While this is discussed more in Unit of Study 4, Intervention with the Dependent Adolescent, the physician should advise all concerned that information is confidential, unless the physician fears harm to the teenager or others.

Many physicians are reluctant to pursue the diagnosis of alcoholism because of their inabilities to provide treatment of the diagnosed condition. They recognize the difficulties involved in providing direct substance abuse treatment, the need for special resources (such as therapy groups), and their own time constraints. It is essential that the physician define for himself or herself and the family the goals for the diagnostic and assessment process. Unless the physician is prepared to actually provide treatment, then it needs to be very clear with the family and the adolescent that assessment is being done to (1) identify or diagnose a problem, its extent, and its severity; and (2) make a recommendation for the service that will be provided elsewhere. It is necessary that the family be assured that there will not be simply a "hand-

off" to some nameless program or agency. Instead, the physician will maintain involvement with the family's health care and will take a special interest in monitoring the progress of the adolescent patient and the family as they receive the recommended service. For the family, the physician can reinforce professional interest by stating in advance that alcohol and drug abuse are medical problems about which there is much to be concerned. The actual treatment and referral process is fully discussed in Unit of Study 5, The Physician's Role in Referral and Treatment.

Obtaining a History: Patient and Family System

The physician obtains data individually from as many pertinent family members as possible and from the patient. A group meeting without the teenager may be worthwhile. Beware of denial!

After establishing the goals and objectives of the diagnostic process, the physician should describe to the person who has brought attention to the matter what is to happen next. This will involve interviewing each of the family members individually, including the identified patient. The physician should schedule sufficient time with each person involved to assure enough time to obtain the necessary data. If appropriate, the physician may conclude by speaking to the parent(s) regarding assessment of the problem (View/Discuss Video VIIb). Should intervention be the recommendation, the process is fully described in Unit of Study 4, Intervention with the Dependent Adolescent (View/Discuss Video VIIc).

In the evaluation of the identified patient, there may be between one and four "parents" involved. This refers to the situation of the "blended family" in which the natural parents have divorced and married others, with the adolescent having contact with both families. Often, valid data can be obtained from all involved parties. Siblings, natural or adopted, can provide invaluable data, and attempts should be made to solicit their input. A group meeting of family members, teacher, and a best friend may be quite helpful (View/Discuss Video V). While it would be ideal to hope to interview all concerned parties, as in any clinical situation, we ultimately have to use what is available. This may mean that the only data available will be from the identified patient and a single parent.

The Chemical Dependency Assessment: Methodology and Technology

Other sources of information include school records and information from prior counselors or even the legal system.

The goals and objectives of the substance abuse assessment are in actuality not dissimilar from that of any medical or health-oriented assessment. The interviewer needs to be able to

1. facilitate the patient's telling his own story,
2. collect sufficient data to make a valid and reliable assessment,
3. organize the data in some sort of coherent fashion,
4. draw appropriate conclusions from the data, and
5. formulate and present a plan of action to the patient and family.

As in other therapeutic interviews, if the process is effective, the patient will achieve greater insight into current conditions and himself.

In the area of substance abuse, however, the patient (and perhaps the family as well) often has a stake in obscuring from the physician, or anyone else likely to impact upon the current situation, as much data as he possibly can. Therefore, from the time the initial contact is made requesting that the physician assess an adolescent patient's current drinking and/or drug situation, it is necessary to begin the data collection process by requesting sources of data not usually sought.

Typically, the request for an assessment of an adolescent occurs after a crisis has occurred — the adolescent presents at school intoxicated, drugs or alcohol are found in his possession in school, there has been an encounter with the police, or some crisis occurred in the home. Upon this initial contact, the physician should request information and documentation relevant to the adolescent's current situation. This would include, but not be limited to,

- reports obtainable from the teenager's school,
- statements and records from any therapists or counselors that the adolescent has consulted with in the last 18 to 24 months, and
- any contact with juvenile justice authorities, such as information available through probation officers.

We would counsel that the physician request the parents or guardians of the adolescent to obtain the information (and reports) from the sources listed above. The welter of privacy and confidentiality legislation makes it extremely difficult for a third party — even with seemingly appropriate releases — to obtain information about another. The physician who attempts to wade through these systems may become stymied; have the parent or guardian directly request these materials and have them conveyed to you before the actual assessment.

While the information provided by these sources will not substitute for a comprehensive personal history, they can be useful in corroborating the reports offered by the adolescent and his family. These data, if available, provide a valuable point of triangulation for any personal history data offered. Contradictions between such external records and self or family reports provide a valuable data source in making an assessment.

Another adjunct to the assessment process can be the use of drugs/toxicological urine screens. Regardless of the findings of the screen, which if positive for any agents should be included in the database, there may be some psychological advantage obtained by it. At the very least, the use of such a procedure is reflective of the "scientific" aspects of health care; laboratory testing fits with the patient's perception of the methods of diagnosis. More specifically, since the adolescent patient seldom knows what urine testing can effectively reveal, having provided a sample and then having the results of it known to the physician places the physician at some psychological advantage in obtaining a drug history. Knowing that the physician has "scientifically produced" data available, the teenager may be more willing to be open about his usage pattern.

Because an adequate assessment cannot be done in just a few minutes, the physician should schedule interviews with the adolescent for blocks of at least 45 minutes duration for the assessment. It is useful at this initial contact for the physician to explain that the assessment may take more than one interview; these should be scheduled at that time. If the assessment is completed during the first block, then other time blocks — scheduled several days later — can be freed for other work.

To review, the assessment begins with an interview with the adolescent and all of the family members (and relevant others accompanying him). This introductory session, generally lasting five to ten minutes, outlines the physician's goals and objectives for the assessment and the expectations of the family and adolescent. Then, beginning with the adolescent, each member of the family is interviewed separately.

Interview Technology

It is important to emphasize again that the chemical dependency assessment interview is not dissimilar to any other health or medical interview. The physician needs to facilitate the patient's (and family's) telling of the story, to help focus them on the process so that relevant data are provided, and to terminate the process when sufficient data have been obtained. Perhaps even more so in this situation than in others, the physician needs to create an atmosphere which encourages rapport and disclosure. He or she needs to be exquisitely aware of the negative variables that impinge on this atmosphere and make every effort to overcome them. Factors which encourage the patient's perception of the physician's empathy and acceptance, as well as the perception of privacy (both psychologic and actual) need to be encouraged.

The Adolescent: Opening the Interview

Your teenage patient will likely be hostile; allow the patient to present his own history, using open-ended questions.

Typically, the adolescent presents in a hostile or defensive posture. He is present at the assessment because of a crisis involving drinking or drug use or the suspicion thereof (View/Discuss Video X). He is angry with his parents and other authority figures in his life, and readily identifies the physician as aligned with them. Seldom, however, will he verbalize these feelings. Any attempts by the physician to mollify these feelings generally are unsuccessful. Also, the time constraints imposed by the assessment itself mitigate against any kind of constructive confrontation with the adolescent's feelings. Instead, it is more productive to acknowledge the patient's feelings, and affirm his right to own them. Using such a posture, it is possible to "agree-to-disagree" about how the world works and still proceed with the task at hand.

Immediately inquiring about drug usage or drinking is nonproductive. It readily confirms the adolescent's preconception about the nature of the assessment and can make him even more defensive. However, by again acknowledging that the visit has been provoked by a

crisis — or at least a disruption — in the teenager's life and that the situation involved has at least two sides, and so far all that has been heard is the one offered by parents or some other authority figure, it makes it possible to invite him to tell his side of the story and to describe from his own perspective the events that led up to the crisis (View/Discuss Video III). This provides the young person with the opportunity to begin telling his own story.

The description of the specific event lends itself readily to lines of inquiry allowing the teenager to describe how his family has reacted to the incident, and the reaction of others — including peers — around him to what has happened.

Early in the interview process, make it clear that you are interested only in him and that if you ask questions about friends, it is for clarification and that you do not want identifying information such as last name and the like. Open-ended questions are much, much more productive than closed-ended questions. At each point, ask for clarification and specification, and, most importantly, request behavioral examples.

Data need to describe changes that have occurred in the adolescent's life that may relate to his drinking or drug usage. Since this is such a rapid period of change in development, intervals of three to six months are appropriate milestone marks. Again, it is essential that behavioral examples are obtained. This is where the perspective on the young person's situation will be obtained.

To provide the understanding of the patient's relationship with alcohol, have the teenager discuss his changing use patterns during initial experimentation: when use occurred, who was present, how he felt, and what it did for him.

As you begin taking the drinking and drug history do not separate it from other aspects of the adolescent's life. For example, ask him to describe his initial experimentation with alcohol: when it occurred, who was there, how he felt about it, and what it did for him. Proceed to queries about more recent events and any changes in consumption patterns or tolerance. Ask for his feelings about drinking, how he feels when he drinks, and what he thinks his drinking seems to do for him. These data will provide a picture of the adolescent's relationship with alcohol (and other drugs).

For example, some health professionals find it comfortable to lead into the questions after inquiring about the smoking history. A typical dialogue may be:

Physician: "Do you smoke cigarettes or other tobacco?"

Patient: "I guess you could say I do."

Physician: "How many packs a day?"

Patient: "Somewhere around two."

Physician: "Do you use snuff or other smokeless tobacco?"

Patient: "Only when I play softball, then I grab a can of snuff."

Physician: "How do you use alcohol?" (Notice the difference in asking this question as opposed to, "How much do you drink?")

Patient: "I never touch the stuff!"
or
"I don't drink."
or
"I quit six months ago."
or
"A couple of beers a night."
or
"As much as I can afford."

A helpful question to ask yourself is, "Does drinking interfere recurringly with any aspect of this person's life?" If the cumulative answer is yes, the physician has some evidence that this teenager is at least harmfully involved with alcohol.

It is also important to determine the source of the young person's alcohol or drugs, not to report it to the authorities, but rather to determine his usage pattern. For example, the teenager who can buy his own marijuana is further advanced in his usage pattern than the young person who only smokes it when provided by a friend.

Be sure to ask the teenager about his family's substance use.

It is vital to ask the youngster to describe his perceptions of parental and other family members' drinking (and/or drug use). Encourage him to compare

and contrast his own use to that of the family's. Here too do not forget to get behavioral examples outlining his descriptions.

Family Members: Technology of the Assessment Interview

Family members should be asked about specific incidents and the impact of these incidents upon the family. Identify changes in behavior that have recently occurred.

Structurally, the assessment interview for family members is not dissimilar to that of the identified patient's. It begins with inquiry at the most general level and gradually narrows to obtaining (more) specific data, finally focusing on those areas necessary to inform the diagnostic process.

For family members, begin by asking them to once again recount their impressions of the specific incident (or incidents) which motivated the assessment. After they provide their understanding of "the facts" of the incident, they should relate their impressions of the teenager's school and social or peer situation.

Each respondent should be asked to describe the impact of the incident(s) or perceived problems which the teenager has experienced on the family's functioning. These accounts can provide a rich source of data about the adolescent's role in the family, the family's level of functioning, and the kinds of support that the family can mobilize to resolve the crisis.

Having dealt with the specific incident(s) and using a chronologically structured approach, data are elicited about the teenager for the preceding 12 to 24 months, focusing on perceived changes in school performance, leisure activities, interests, peer associations, behavior within the family, and any other areas that the family deems important. Encourage the parent(s) to provide data—with as many behavioral examples as possible—on general behavior and do not restrict the report to only those areas that are concluded to be problematic or drug-related.

Do not hesitate to obtain data about drug and alcohol use by all persons.

Data about the parent's own drinking and drug use should be obtained. This line of questioning is initiated when you believe that rapport is greatest; the inquiry should be grounded within larger behavioral patterns, such as dietary habits, sociability, recreation, and the like.

The evaluation should include drinking and drug use data on each family member. Do not be satisfied with cursory labels such as "social drinker" or "a few beers." Instead, ask specifically about drinking patterns and, most importantly, the ramifications of drinking in the major life areas. These are sensitive areas, so questions must be posed in neutral, nonjudgemental ways.

In the assessment of familial risk factors, inquire about the presence or history of alcohol or drug problems in the identified patient's blood relatives within the three generations of the nuclear family. If any "problem" is indicated, then ask the family member to describe it in greater detail.

From the perspective of their current situation, some family members will not wish to "rock the boat." While they are not happy with what may be occurring within the family, the prospect of additional turmoil or change is greeted with much anxiety. Obtaining information to provide a valid assessment in a brief period of time will challenge the physician. The challenge, however, is well worth it (View/Discuss Video IX).

Data collection necessarily begins at the first moment of contact with the patient and the family. The physician should carefully note how members of the family relate to each other. Subtle information from family members will suggest much about the family's pattern of communication. Easier, more open communication among family members suggests that the family is functioning at a fairly healthy level. An example of a family not functioning at a healthy level is one in which the physician astutely may recognize that a woman's recent bout of back pain is secondary to problems with her teenage son. Knowledgeable physicians are attuned to the health problems of other members of the family. Stress has been correlated with the onset of organic illness.

The physician needs to facilitate the patient's telling the entire story. Use of open-ended questions to accomplish this is demonstrated in several of the video scenarios. However, it is unlikely that the patient will be able to or willing to provide all of the necessary data himself. Conversely, information about what is occurring in the family as reported by the parent(s) may also be highly selective and biased. Therefore, the physician

needs to obtain the perspective of as many of the various individuals as possible to complete the assessment. This includes a behavioral inventory being obtained to determine the degree of drug involvement. Remember in the process that the history of progressive changes usually provides a better guide to appropriate therapy than the actual drug-use history.[3] Each member should describe not only his or her impression of the identified patient's current situation, but also his or her role in the functioning of the family. Discrepancies become indicators of problematic areas within family functioning and are vital data in making the assessment.

The model recommended to obtain diagnostic information from teenagers reflects the problem-oriented framework. This model may be used for a patient brought to your attention as having an alcohol abuse problem or in screening for abuse in the routine office care of our youth. This will include critical aspects in the medical history, physical examination, assessment, and care plan (SOAP system: subjective data, objective data, assessment, plan).

Medical History

Routine family history should include presence or absence of alcoholism. There is very strong evidence for the genetic component of this illness.

Prior to obtaining the drug-taking history, as outlined later, the physician should be tailoring questions in the routine medical history to include alcohol-related issues. Specific examples include:

1. In the family history, add alcoholism when asking standard questions, such as "Are there any diseases that run in your family such as diabetes, cancer, alcoholism, or heart disease?" This is quite reasonable knowing that alcohol can be a familial problem and knowing how great a risk teenagers really are for substance abuse. Familial aspects of alcoholism were discussed at length in the first two units of study of this series, but a brief review of the importance of genetic factors is worthwhile.

   Numerous studies, including twin studies, have demonstrated the strong genetic predisposition of some individuals toward the disease of alcoholism.[4] One of the most convincing efforts conducted by Goodwin et al. showed a fourfold greater concordance between adoptees and their biological parents versus their adopted parents![5] An impressive 1985 review on genetic factors by Marc Schuckit, M.D., is strongly recommended for review.[6] His report includes a summary of studies of those individuals that physicians should single out for special attention, such as the young males with a close alcoholic family member. The physician uncovers this special risk by a good family history. Schuckit notes that this group appears to have less intense responses to modest doses of alcohol; the resulting theory suggests that the high-risk individual is less able to judge when he is getting closer to being intoxicated and is less likely to stop before actual intoxication occurs.
2. In a review of systems or past medical history, you might specifically ask (if not already part of your routine) questions about hepatitis, withdrawal experiences, and depression. Specific indicators of possible alcohol abuse include recurrent trauma, recurrent severe colds, and mood disorders.
3. It is quite important in reviewing medications with your young patients to determine if there is medicine misuse, intentional or not. Also, potential interactions with alcohol and common drugs like antihistamines, analgesics (i.e., propoxyphene), or certain anticonvulsants should be kept in mind.
4. The physician should never forget that tobacco is also an addictive drug. Ask about smoking cigarettes. Do something if smoking occurs. Smokeless tobacco use is now epidemic, and specific inquiry about its use is warranted.

Clinical situations such as overdose or automobile accidents are "red flags" for the physician. Presence of the major risk factors—heredity, stress, poor support systems, and availability of alcohol—should signal the physician to pursue the diagnosis.

Certain other illnesses in the medical history will be "red flags" that should force you to explore a drug history later on. Some examples may include an overdose situation, a hospitalization for trauma resulting from an auto accident—especially a single-car accident—or a new onset of a seizure disorder when the work-up was negative. Trauma secondary to fighting should also be suspect.

Of even greater importance in determining how aggressive the physician should be in pursuing the possibility of alcohol abuse is the presence of risk factors. The four key risk factors for alcoholics are

> *heredity,*
> *availability of alcohol and other drugs,*
> *peer and/or support system influences, and*
> *stress, both external and developmental.*[4]

The presence of risk factors is a strong signal to the physician to pursue the possibility.

Of course, you should be wary of diseases or conditions in which any alcohol use should be avoided. These include seizure disorders, diabetes, and pregnancy. Be sure to ask if the patient has ever been cautioned about not drinking, given special health circumstances. If drinking continues in spite of a previous warning, then be very suspicious of a problem and pursue this line of questioning.

At this point in the interview, a natural step is to inquire about drug use, either past or present. Again, at first, tangential questions are more useful than direct ones. Since some teenagers are sophisticated with alcohol and since virtually all who have difficulties with alcohol use other drugs, it is often helpful to approach the subject by inquiring about prescription drugs, with phrases such as: "Has a doctor ever prescribed a pain pill, sleeping pill, or tranquilizer for you?" This type of question may set the stage for more openness by the patient. Then questions posed in generalities about peer activities relevant to drug use become an easy way to broach the patient's own use. Here too, be sure to approach the issues with a chronological perspective. Be especially sensitive to changes in the patient's usage pattern.

Drug-use history-taking can be learned with a minimum of practice. Objective data can and must be obtained to solidify the assessment of alcohol- or drug-abuse problems. Certain specific questions you may wish to incorporate in your history might depend upon the definitions you choose; these will be further discussed under Assessment.

Phsycial Examination

The physical examination of adolescents who abuse alcohol is usually normal. But it is still important, especially the neurological and the mental status aspects.

A teenager usually does not have the classic signs of alcohol abuse as observed in a patient with cirrhosis who has a markedly enlarged liver, ascites, and jaundice. Earlier signs of alcoholism, though uncommon in teenagers, may include mild tachycardia, unexplained scars, or borderline hypertension.[7] On most occasions, you will probably find an unremarkable young patient in front of you. Thus, most of our emphasis in this unit of study has been on behavioral history. It is definitely not normal to observe alcohol on someone's breath, needle tracks, a tremor, or constricted pupils. Icteric sclerae obviously merit your concern; but do not forget that your patient may instead have infectious hepatitis. Such findings deserve further careful evaluation by the physician. Signs of depression, such as psychomotor retardation or loss of interest in normal activities, should be explored and evaluated.

Other aspects of the physical examination should be mentioned. Abnormal lung fields detected on examination (or a history of recurrent bronchitis) should raise suspicion of cigarette smoking or marijuana use.

Occasionally, a teenager will be patently intoxicated or appear to be under the influence of alcohol or drugs. This state needs little elaboration; intoxication should be noted if present, and a chemical screen including a blood alcohol level should be ordered. Ataxia may imply concomitant hydrocarbon abuse if it is prominent. Other aspects of the neurological evaluation are also quite important, even more so if the patient has been actively drinking. Be careful not to blame neurological change on ethanol automatically; perhaps head trauma has caused central nervous system bleeding. Certainly nystagmus, ophthalmoplegias, and peripheral neuropathies need to be looked for; although finding them is uncommon, this does not release the physician from the search.

A mental status examination is quite important. Unfortunately, this aspect of a physical examination often gets forgotten after the required psychiatry rotation. Has there been a change in the youth's judgement? How about remote and recent memory? Have you noted appearance, behavior, orientation, and emotional tone? Evaluation of suicide risk and thought content obsessions, phobias, delusions, ambivalence is essential for a proper medical evaluation. Indeed, this aspect of the examination is more likely to demonstrate abnormalities than others. Consider simply the nationwide concern about teenage suicide. To repeat a critical point—the general rule for teenage alcohol abusers is that the physical examination is unremarkable. However, do not be fooled!

Construction of Assessment Data Base

The physician needs to consider data from all sources.

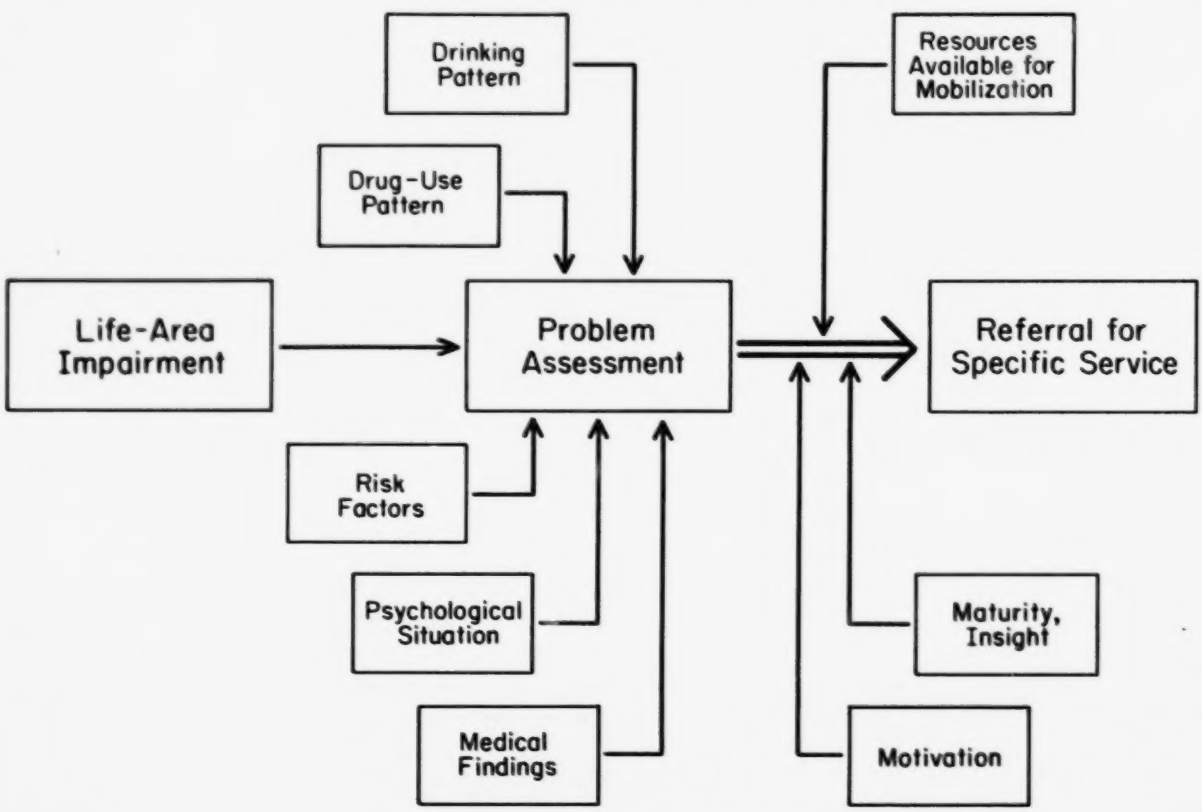
Figure 3-3 presents a schematic of the assessment process. It outlines the larger categories of data to be obtained from the identified patient and then triangulated through with data from other sources such as family and school. These categories of data are then combined by the physician to assess the patient's position on the progression continuum and/or his vulnerability to continued or additional problems.

Factors such as the resources which the adolescent and the family can mobilize for the resolution of these problems, the adolescent's level of insight and maturity, and the extent of motivation to effect change need to be considered. These are important in the construction of the plan of action and referral to the specific agency/program for the recommended service.

At a minimum, the physician needs data in each of the boxes (areas) represented in the schematic. The absence of any will seriously compromise the assessment effort. Therefore, we will discuss these in some greater detail below.

Central to the assessment process itself must be a focus on the ramifications or consequences of drinking and drug use on specific life-area functions. These include (1) family relationships, (2) social relationships, (3) psychological functioning, (4) self-concept or definition, (5)

Figure 3-3. Assessment Schematic



health, (6) school or occupational functioning, (7) legal involvement/problems, and (8) financial problems.

Alcohol or drug "abuse" is seen as use of agents in such a way that it causes consistent problems in any of the major life-areas. Chemical dependence as a diagnosis should be seriously considered when the adolescent persists in his pattern of use despite the interventions of family, school, or social control agencies. A person is said to be "dependent" when there is evidence to suggest that he is either unable or unwilling to modify his drug- or alcohol-using behavior patterns in the face of unpleasant or even painful consequences. Dependency can also be attributed when the use of alcohol or drugs constitutes the major coping mechanism. Dependency is also documentable by a marked increase in tolerance to the effects of alcohol or other drugs or the onset of withdrawal symptoms or distress upon cessation of their use.

Returning to the progression model offered in a preceding section, dependency, in an adolescent, appears to equate reasonably well with the categories of "harmful involvement." These definitions are consonant with the diagnostic categories offered in DSMIII:305.OX/303.9X. However, when dealing with teenagers, specific drug use or drinking patterns can provide a more useful perspective than with adults. In the adolescent, any kind of daily use should be considered a strong indicator of harmful involvement and should raise the suspicion of dependence. The usage pattern itself is perhaps one of the best indicators of vulnerability for subsequent problems—the heavier or more frequent the use, the greater the vulnerability.

Other signs and symptoms need to be seriously considered. These would include, but not be limited to: blackouts, repeated use of chemicals to cope with unpleasant or painful feelings, previous unsuccessful attempts at control, "binges" of intoxication, and solitary use at something other than the most experimental levels (View/Discuss Video X). The psychological variables usually considered include depression, role frustration, anxiety, inappropriate or acting-out behavior, or any other difficulties to which a patient might respond through self-medication. It is also essential to assess the suicide risk of the adolescent. If there is indication of a strong risk—either consistent ideation, prior attempts, or planning—then immediate hospitalization and psychiatric examination/observation need to be recommended.

Synthesizing the Assessment Data

After synthesizing the clinical assessment, formulation of an appropriate plan of care follows.

In combining the data elements provided by the categories depicted in Figure 3-3, the physician is attempting to distinguish a pattern of abuse from dependency. This determination hinges upon (1) the level and extent of life-area impairment, (2) previous attempts to deal with these problems and modify usage patterns, (3) the drinking pattern and situation, (4) the drug use pattern and situation, and (5) the risk factors.

Figures 3-4 and 3-5 present some initial attempts at the construction of a diagnostic matrix. In Figure 3-4, a rough quantification and weighting of impairment and risk factors have been suggested. This matrix starts at the most benign level and proceeds to the most profound. The scale suggested should be seen as qualitative and a way of differentially combining the physician's judgements with the available data. The matrix suggests different levels of intervention as they relate to the various levels of problem assessment and vulnerability.

The index recognizes that there is a differential progression or development of drug problems. Understand that when risk factors are to be included, not everyone "starts at the same place" and that such a matrix formation makes it possible to encompass realistically different substance-abuse career paths. For example, the young person who is currently at the "experimental level" of use, yet is "high at the risk-factor level" and whose psychological situation is problematic, is certainly in need of intervention and treatment. This matrix makes such a multifactorial decision possible.

Figure 3-5 is a more descriptive (narrative) presentation of the same concept. The use of such a matrix allows the physician to visualize the data base of the assessment as process. Naturally, the physician confronted with a patient, the patient's family, and their unique situation will necessarily have to provide his or her own weighting of the discrete assessment elements.

For both the identified patient and the family, use the outline provided by the assessment schematic. It readily provides a summary of the areas—comparable to a review of systems in a medical assessment—necessary to a valid and reliable assessment. Other information—

Figure 3-4. Assessment Dimensions

Usage	Life-Area	Risk Factors	Psychological Situation
1+	1+	1+	1+
2+	1+	2-3	2
2	2	4-5	2
3-4	3	2-3	3-4
3-4	4-5	4-5	3-4
5	5	5	5

One to Five Rating Scale:
One—Suggests little or no difficulty
Five—Suggests the greatest level of importance, difficulty, or risk.

Use
The values are summed horizontally. This would suggest the following treatment/intervention matrix:

Numerical Summation	Problem	Intervention
4-8	Assessment Lifestyle Concerns	Education and support are appropriate
9-13	Moderate problem	Formal treatment program is appropriate
14 or more	Severe problem or great vulnerability	Residential treatment is appropriate

subjective, objective, archival—are triangulated with each other and the central data source. Possible contradictions and discordances are noted and should be seen as markers calling for additional exploration.

Assessment

Be cautious in actually charting the diagnosis of alcoholism. Ascertain the primary problems and secondary ones. Your diagnosis may depend on your definition.

When putting together your medical assessment of the problem(s) at hand for your teenage patients, you must keep in mind the possibility of substance abuse as an underlying cause. This problem should not always be a diagnosis of exclusion. However, you must also be wary of routinely including substance abuse as a possible major factor in a patient's medical chart since your records may be referenced at some point for purposes such as life insurance or a job. One cannot overestimate the need for the great care with which your thoughts are placed into someone's medical chart in the phase of care when diagnoses are uncertain. A reasonable example of careful charting of a medical assessment in the problem-oriented medical record can be as follows: "Based upon the history and the physical examination which demonstrated thyromegaly, John's tremors seem most likely related to hyperthyroidism. But should his thyroid studies prove to be normal, other alternative diagnoses might include severe anxiety, a metabolic disorder, substance abuse, or withdrawal." It is not fair to your patient to make a brief, hurried note that can come back to haunt him, such as: "Tremor, new onset. R/o drug abuse, R/o hyperthyrodism, R/o anxiety." In any case, be sure to include behavioral examples or even quotes from patient and family. These will not only be the most useful in your ongoing management of the case, but will also be the most defensible should your opinion be challenged.

The physician must be careful as to the primary diagnosis. In some cases, increased alcohol intake may be a symptom of an underlying depression. The latter problem responds to different treatment plans, with pharmacotherapy probably being able to make a greater contribution in management. While experts contend

Figure 3-5. Problem Assessment—Intervention Level Matrix

Assessment Dimensions	Clinical Assessment/ Numerical Determination	Intervention
Usage pattern Life Area Impairment Risk Factors Psychological Situation	Experimental Minimal Minimal Good	Education, Social, and Psychological Support
Usage Pattern Life Area Impairment Risk Factors Psychological Situation	Social/Recreational Minimal Moderate Adequate	Education, Social, and Psychological Support Careful Monitoring of Case
Usage Pattern Life Area Impairment Risk Factors Psychological Situation	Social/Recreational Minimal High Problematic	Formal Outpatient Program
Usage Pattern Life Area Impairment Risk Factors Psychological Situation	Committed Moderate Moderate Adequate	Formal Outpatient Program
Usage Pattern Life Area Impairment Risk Factors Psychological Situation	Committed Severe High Problematic	Inpatient/Residential
Usage Pattern Life Area Impairment Risk Factors Psychological Situation	Dysfunctional Severe High Problematic	Inpatient/Residential

that the alcohol issue still needs to be addressed prior to tackling other problems, your willingness to prescribe medications will be influenced by the patient's drinking or drug-use situation, or both problems may be equally important. Either way, a logical plan of care depends upon your clinical assessment of the patient's problem(s), interrelated or not.

The actual assessment or presumptive medical diagnosis as it relates to alcohol is best made in terms of where the patient fits onto the progression scale of the disease process, keeping in mind that there is more than one path of this progression. Actually diagnosing alcoholism requires that the individual be at least at the harmfully involved phase of the scale. In making your diagnosis, it may be useful to review several definitions relating to alcohol abuse. You can choose which works best for you and your patients.

1. *World Health Organization:* Alcoholism is a chronic behavioral disorder manifested by repeated drinking of alcoholic beverages in excess of dietary and social uses of the community and to an extent that it interferes with the drinker's health, social, or economic function.[8]

2. *Psychiatric profession:* One of the "substance use disorders"; diagnostic criteria for alcohol abuse include a pattern of pathological abuse, impairment of social or job functioning due to alcohol use, and duration of disturbance for at least one month; alcohol dependence implies either a pattern of abuse or impairment, plus tolerance or withdrawal phenomena.

3. *The Chafetz definition:* Alcoholism is a chronic behavioral disorder that manifests itself in an undue preoccupation with alcohol, in its use to the detriment of physical and mental health, in a loss of self-control, and in a self-destructive attitude in dealing with personal relationships and life situations.[8]

It is very important to remember that these definitions are offered for adults. However, they still relay some kinds of functional or behavioral impairments that you will be looking for in your history-taking relative to adolescents. The exact diagnostic label is less important than the frank documentation of consistently occurring difficulties.

Assessment and Compliance: The Physician's Limits

Compliance with proposed treatment depends on available resources. Formal intervention may be necessary for many adolescent patients.

In additon to documenting the presence of problems, their etiology, and an appropriate treatment strategy, the assessment must explore the kinds of resources that the patient and the family can mobilize for the resolution of their problems. Like other conditions, compliance or follow-through with the recommended treatment is often the most problematic part of the process.

Compliance is particularly problematic with substance abuse services. If a family member is chemically dependent, the family has likely reconstituted its patterns of interaction to accommodate, or at least not challenge, the affected individual. The first crisis may simply not have the power to shake these patterns and move the troubled member and family into treatment. A strategy for a more effective intervention is presented in the next unit of study, Intervention with the Dependent Adolescent. The abuser tends to stubbornly cling to the belief that use is really nonproblematic and that the difficulties experienced relate entirely to the misguided efforts of others. He is entirely oblivious to his increasing vulnerability. These beliefs can be particularly tenacious among adolescents since the role demands made upon them are minimal. They are sincerely surprised when they are the ones who are in trouble.

From the parents' perspective, the only psychological defense to a worsening home situation is denial. While they can describe changes in their teenager's behavior, they are usually unwilling or unable to make the connection between drug use and these changes. They are frankly frustrated that all attempts at control through reason, discipline, and perhaps even counseling have been unsuccessful. For change to occur, the connection between use and problems needs to be recognized. Since the connection can only be made by the person himself, the physician's role is structured around providing perspective, information, and guidance. The patient and family should at least hear about the process of chemical dependency progression, the patient's place on it, and the likelihood that the problems which are occurring will not resolve themselves.

Because education is a key element of treatment, the physician should describe for the patient and the family the entire continuum of substance abuse and attendant problems. Using language that is nontechnical and neutral, the physician will locate the patient along this continuum, based upon the available data. The physician will frankly admit that no one has a "crystal ball" capable of predicting the future; however, given the knowledge about the progression of the condition, additional and even worse problems can be anticipated. The physician will then describe what he believes has to be done or may defer recommendation for formal treatment to an intervention meeting if he feels that this is appropriate. The assessment will end by offering a specific recommendation for treatment and the necessary information to the patient and family about how to obtain it, or arrangements are made for a formal intervention.

The unwillingness of the patient and the family to accept specific findings and to follow the recommendation reflects their unwillingness or inability to accurately see their current situation. It may very well be that both the troubled member and the family need to experience even more difficulty related to the drinking to convince them that the conclusions that have been drawn about the problems and the solutions are indeed proper ones. Therefore, even though recommendations at times are rejected, the physician should maintain an open, accepting posture toward the patient and the family, with the expectation that he or she will be successful in directing them into treatment some time in the future.

Diagnostic Testing

Although a CBC or liver enzymes may be abnormal, most blood tests are normal in teenage alcohol abusers. Blood alcohol level (BAL) may be helpful in certain specific situations.

Diagnostic testing for possible alcohol abuse may include certain tests beyond the blood alcohol level (BAL). The CBC can be a useful screening test by demonstrating an elevated mean corpuscular volume (MCV). This may be more significant if liver enzymes are also elevated. The gamma glutamyl transferase is the most sensitive (though less specific) of the liver enzymes. Elevated SGPT (ALT) or SGOT (AST) would also be significant. However, teenagers usually do not show these abnormalities as frequently as do older drinkers. The physician must be cognizant of other etiologies if liver enzymes are elevated, such as mononucleosis or hepatitis. Clearly the emergency situation demands complete blood and urine levels of the substances of abuse.

A urine toxicology screen can be used in the diagnostic studies, especially with "polypharmacy" as is often the case with young people. Care must be used that you are candid with your patient. Also keep in mind that patients are minors under the age 18, which may affect your obtaining various tests and consent. The value of current blood tests and x-rays to evaluate organs known to be damaged by alcohol such as the pancreas (amylase) and the brain seem to be of unproven value in the earlier stages of alcohol abuse unless there is a specific indication. Although most substances are cleared from the youthful body in short order, the urine toxicology screen may well demonstrate cannabinoids seven to ten days after abuse has stopped and is thus a reasonable office screen.[3]

The blood alcohol level can be tested and immediately read in the office or the emergency department using a pocket-sized device such as the Alco-Sensor II.* If the BAL is more than 100 mg% (0.1 gram) without gross evidence of intoxication (such as slurred speech, an ataxic gait, or over-relaxation of facial musculature) a well-developed tolerance to the effects of alcohol can be established. With these data available the physician can then check the veracity of other self-reported data and challenge them when appropriate. Also, if the BAL is 300 mg% (0.3 gram) or more, regardless of symptoms or signs, it encourages the diagnosis of alcoholism,[7] because the 150 to 300 mg% BAL's in an awake person imply the presence of a high degree of pharmacological tolerance, which can be a major diagnostic criterion for alcoholism. Remember, that a negative or zero reading means nothing other than that there is no alcohol in the person's body. If the person does appear intoxicated even in the face of the data, be sure to order tests capable of detecting the presence of other mood-altering drugs.

The BAL should be treated as a corroboratory medical test that is useful in helping the physician or health professional reach an accurate assessment or diagnosis. Thus, it is a test to be used only in a positive helping capacity. It should not be used in a negative or punitive capacity, and it should be kept confidential, as any other part of the patient's medical record.

Since alcohol contributes to the death of nearly 5000 teenagers a year on the highways, some additional perspectives on BAL would be useful for your patient education activities. Most states use 100 mg/dl (0.10%) as the legal definition of driving-under-the-influence (DUI); but in 1986, the American Medical Association went "on record" as recommending that all states use 0.05% BAL as the criterion for conviction of DUI.[8] This was based on a review of numerous scientific findings that for most people alcohol above this level causes a deterioration of driving skills. However, a review of the literature demonstrates that young people are not only inexperienced drivers but are usually inexperienced drinkers as well. Therefore, teenagers in fatal crashes show even lower BALs than older drivers. Thus, there is no "safe" level. The *JAMA* reference in this paragraph is strongly recommended. This message should be communicated to all of your teenage patients.

Terminating the Interview

Terminating the diagnostic process (the assessment) may involve both individual and group interviews.

The physician might consider three separate termination interviews. For the adolescent, when you have collected sufficient data or have exhausted your ability to obtain additional relevant data, present the adolescent with a schematic of the major life-areas, including usage patterns and risk factors. Invite him to summarize the information that he has provided about each and to assess his own level of impairment/difficulty/involve-

*Available from: Intoximeters, Inc., 1901 Locust St., St. Louis, MO 63103.

ment on each of these. Then present him with an outline of the progression hypothesis and ask him to place himself along the continuum on the basis of the data that he has provided. Discuss his self-assessment within the context of the categories and perspectives; this becomes the termination of the interview.

The same process can be used with the parents or family. Using the structure provided through the schematic, the respondent(s) are invited to summarize the data that they have provided and their impressions of where their youngster belongs on each of the dimensions. Having done so, offer an outline of the progression continuum and ask them to place their teenager on it. At the same time, they should be encouraged to identify an intervention level (service level) which they believe might reduce the level of vulnerability that their teenager is currently experiencing or which might address the specific problems to which they have alluded. Your direct feedback constitutes the termination of the interview with the family.

The third termination session, which involves the family and the adolescent together, reviews your assessment of the identified patient's place on the progression continuum and your recommendation for actual service. You then briefly but carefully summarize your impressions, distinguishing between data and interpretation. Value-laden words such as "addicted," "alcoholic," or "drug addict," should be avoided, using instead neutral, less inflammatory concepts such as "harmful involvement" and "dependence."

Since these findings have already been provided to the adolescent and the family, they can be very briefly summarized in this third meeting. The assessment concludes with your recommendation for intervention and, most importantly, what this service can provide for the adolescent and the family. As noted earlier, if you feel in a given situation that the above process is not appropriate for a specific teenager because the family lacks control, the "standard intervention," which can be more surprising to the teenager, can be used. This is described in the next unit of study.

A Final Note

Interviewing, history-taking, and assessment are developed skills. While the process described above may appear at first reading to be cumbersome, it is in actuality much like a medical assessment. Perfection and speed come with practice. Like any other skill, there are few immutable rules. Each physician identifies and perfects the techniques that work best for him or her. However, committing yourself to an explicit model assures that the data you collect are comprehensive and can lead to an action plan.

Summary

We have reviewed the complex, behavioral factors in the development and diagnosis of alcoholism. This behavioral component is critical for physicians to master since teenagers do not usually show the end-stage findings of alcoholism. Alcoholism can be approached as other diseases in a problem-oriented fashion. We have thus reviewed this illness in a subjective, objective, assessment, and plan-of-care approach. The key elements are in the history, which the physician should attempt to obtain from as many concerned individuals as possible.

Evaluation

Four stages of substance abuse are outlined in this unit of study. These stages are experimental use, social/recreational use, committed/harmfully involved, and dysfunctional abuse. A distinction is made between the first two and second two use patterns, with emphasis being placed on the need to educate and guide those who are experimenting and using socially or recreationally and the need to diagnose and intervene when a person crosses the line to the harmfully involved and abuser stages. The key word in this progression of stages is dysfunction. As a physician, it is essential that you recognize dysfunction as a potential symptom of alcoholism or substance abuse. To assist you in this process, we ask that you fill out the following matrix which includes on one axis the six major areas in which dysfunction occurs. In each cell, place appropriate symptoms or tests that would indicate dysfunction. After you have completed this table, share it and discuss it with colleagues and, if possible, one or more alcoholism and substance-abuse specialists.

Alcoholism and Substance Abuse Diagnostic Matrix

Area in Which Dysfunction May Occur	I Sources of Information Regarding Functional Status	II Specific Tests Examining Functional Status	III Symptoms or Test Results Indicating Dysfunctional Status	IV Possible Explantations for Symptoms or Results Other Than Alcoholism or Substance Abuse
Family				
School/Work				
Social Relationships				
Self-Concept and Self-Esteem				
Psychological Function				
Physical Well-Being				

When you entertain the possible diagnosis of alcoholism or substance abuse, you may wish to fill in the blank matrix specifically for your patients. The presence of strong indicators of dysfunction in Column III of the matrix without acceptable alternative explanations in Column IV would be a strong indicator of alcoholism or substance abuse.

After you have used the matrix several times, discuss its application with your colleagues. If you feel its use is supported, include it as a regular portion of your diagnostic work-up for adolescent patients presenting with problems associated with potential alcoholism or substance abuse.

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Resources for Physicians

1. Chafetz, M.E.: *The Alcoholic Patient: Diagnosis and Management.* New Jersey:Medical Economics Books, 1983.
2. Liepman, M.R., Anderson, R.C., and Fisher, J.V.: *Family Medicine Curriculum Guide to Substance Abuse.* Kansas City, MO:Society of Teachers of Family Medicine, 1984.

Resources for Patients and/or Families

Your community mental health center or local substance abuse treatment facilities will probably have pamphlets that are most appropriate for the problems and treatment approaches that exist in your particular setting.